**FOO FIO NA**

**v.**

**HOSPITAL ASSUNTA & ANOR**

HIGH COURT MALAYA, KUALA LUMPUR
MOKHTAR SIDIN JCA
[CIVIL SUIT NO: S7-25-13-87]
8 OCTOBER 1999

***TORT:*** *Negligence - Medical negligence - Doctor's duty of care - How is court to conclude whether doctor negligent - Whether doctor may be negligent even if normal or standard practice followed - Patient completely paralysed after first surgery - Whether caused by doctor's negligence - Failure to take immediate remedial measures - Whether amounts to negligence - Whether doctor failed to exercise care and skill of ordinary competent practitioner - Second surgery conducted in the absence of consultant who pointed out necessity for remedial surgery - Whether doctor negligent for operating alone*

***TORT:*** *Negligence - Medical negligence - Warning as to risks of surgery - Whether failure to give proper warning amounts to negligence - Doctor assured patient that surgery was a minor one - Patient paralysed due to operation - Whether patient would not have consented had he known of risks*

***TORT:*** *Negligence - Medical negligence - Patient's consent to undergo surgery - Whether obtained properly - Consent to surgery included in hospital admission form containing standard consent clause - Need for surgery not known when admission form filled up by patient - Risks involved in surgery not explained to patient - Whether patient consented to undergo surgery - Whether amounts to medical negligence*

***TORT:*** *Negligence - Medical negligence - Patient's consent to undergo surgery - Consent bearing completely paralysed patient's thumbprint - Patient denies consenting - Whether burden on doctor to prove voluntariness of consent in such situation - Whether failure to discharge burden amounts to medical negligence*

***EVIDENCE:*** *Expert evidence - Doctor - Opinion given without examining patient or viewing patient's x-rays - Whether court ought to accept evidence*

***EVIDENCE:*** *Expert evidence - Independence of - Council member of society established to protect doctors from negligence suits giving evidence for doctor in negligence suit - Whether evidence self-serving - Whether evidence not a neutral opinion of patient*

***TORT:*** *Vicarious liability - Doctor and hospital - When is a hospital vicariously liable for doctor's negligence - Whether doctor a servant or agent of hospital*

***DAMAGES:*** *Personal injuries - Quadriplegic - Quantum - RM180,000*

***DAMAGES:*** *Personal injuries - Loss of earnings - Incident prior to amendment to Civil Law Act 1956 - What is the reasonable working life span of a female - Whether salary increments ought to be considered*

***DAMAGES:*** *Personal injuries - Nursing care - Whether fact that loss of earnings awarded ought to be considered in determining amount to award for nursing care*

The plaintiff was involved in a motor accident and was admitted to the first defendant hospital. On being admitted, the plaintiff filled up a hospital admission form which included a standard stipulated consent ('the first consent') for any operation which the medical officer may consider necessary. At the time of admission, the plaintiff was able to move her body and limbs though she felt some pain at the neck. The morning after her admission, she was examined by the second defendant who informed her that her injury was "a small problem". Two days later, as the plaintiff was not responding to the conservative treatment prescribed, the second defendant recommended surgery ('the first surgery') to be performed. After the first surgery, the plaintiff was not able to move her body and limbs. Two weeks after this, upon one Dr. Mohandas conducting a myelogram test, the plaintiff was again operated on by the second defendant ('the second surgery') but Dr. Mohandas was not present during the second surgery. There was in evidence another consent form ('the second consent') dated after the first surgery which bore the plaintiff's thumbprint. After the second surgery, the plaintiff recovered the use of her upper limbs. Thereafter, the plaintiff remained at the hospital for eleven months without recovering the use of her legs. X-rays taken of the plaintiff were not produced in court as the second defendant claimed that those x-rays could not be found.

The plaintiff claimed that the second defendant was negligent due to, inter alia, the following: (i) the risks of the first surgery were never explained to the plaintiff and instead the second defendant assured her that the first surgery would be a simple one; (ii) had the plaintiff known that the first surgery was a major one involving high risk, she would not have consented; (iii) no one explained the necessity of the second surgery to the plaintiff and she never consented to the same; and (iv) the insertion of a wire loop into the plaintiff's neck in the first surgery caused the compression of the spinal cord thereby resulting in the plaintiff being paralysed. The plaintiff further contended that as the second defendant was the servant or agent of the first defendant, the

first defendant was vicariously liable for the second defendant's negligence. The plaintiff thus prayed for special and general damages.

**Held:**

**[1]** The principle underlying medical negligence cases is that the court has to decide on the doctor's negligence after weighing the standard of skill practiced by the relevant profession or trade and also upon considering the fact that a person is entitled to make his own decision on his life. What is expected of a doctor is that he is to exercise a fair and reasonable standard of care and skill expected of an ordinary competent medical practitioner. Even though the normal or standard practice is followed, a doctor may still be liable for negligence if something went wrong with the follow-up treatment such as lack of observation.

**[1a]** The paralysis was caused by the wire loop compressing the spinal cord and this was confirmed by the fact that when the wire loop was removed during the second surgery, the plaintiff was able to move her upper limbs. Hence, the second defendant was negligent in conducting the first surgery. The second defendant was again negligent when he did not take any step to remedy the paralysis immediately but instead waited for two weeks before conducting the second surgery. The second defendant thus failed to exercise the care and skill of an ordinary competent practitioner in his profession.

**[1b]** The myelogram never crossed the second defendant's mind until it was done by Dr. Mohandas. Had the second defendant conducted this test before the first surgery, he would have discovered that the first surgery would not be necessary or that it ought to be done by a specialist. Dr. Mohandas was the person who pointed out the need for the second surgery and yet the second surgery was conducted in his absence. Therefore, the second defendant was negligent when he conducted the second surgery in the absence of the consultant who had pointed out the case of the paralysis

**[2]** On the date the first consent was given by the plaintiff, which was upon her admission to the hospital, it was not known whether there was any necessity for the plaintiff to undergo an operation. Thus, it would not have been possible for the second defendant to explain the procedure and risks of the first surgery to the plaintiff when the plaintiff had given the first consent. Therefore, she was not told of the risk of paralysis as a result of the first surgery. The failure to do so and the misrepresentation by the second defendant that it was a minor surgery clearly shows that the plaintiff would not consent to such an operation and the consent, if any, was not obtained properly. Therefore, the second defendant was negligent in not giving a proper warning to the plaintiff.

**[3]** The second consent was given after the first surgery when the plaintiff was totally paralysed. As a result of being paralysed, she could not have affixed her thumbprint herself nor could she have resisted the affixing of it if someone did it for her. As the plaintiff denies having consented to the second surgery, the burden was on the defendants to satisfy the court that the consent was given voluntarily. This burden, however, was not discharged.

**[4]** The x-rays, which were in the defendants' possession, were vital to both sides especially so for the plaintiff but it was never produced in court. In view of the unsatisfactory explanation for the non-production of the x-rays, the court has no alternative but to invoke s. 114(g) of the Evidence Act 1950 against the defendants.

**[5]** A doctor cannot give any opinion, what more an expert opinion, without seeing and examining the patient and, in the present case, without seeing the x-rays of that patient. The defendants' expert's opinion was based entirely on the case notes given to him by the second defendant. Further, the defendants' expert was a council member of the medical protection society which is established to protect any undoing or negligence of a member. The second defendant was a member of that society and as such, the defendants' expert's evidence is self-serving and not an independent and neutral opinion of the patient.

**[6]** The onus is on the plaintiff to prove that the second defendant was the servant or agent of the hospital. At the material times, the second defendant was employed by the hospital. The plaintiff sought treatment from the hospital and she agreed to pay the fees for treatment to the hospital. The second defendant was assigned by the hospital to treat the plaintiff. Whatever payments to the second defendant were made by the hospital as salary. The plaintiff did not specifically request for the second defendant to treat her and neither did she promise to pay the second defendant for his services. Thus, the second defendant was a servant of the hospital at the material times. Therefore, the hospital was vicariously liable for the negligent acts of the second defendant.

**[7a]** The plaintiff is now a quadriplegic and is unable to do things on her own. The amount to be awarded for general damages should be RM180,000.

**[7b]** As the unfortunate incident occurred before the amendments to the Civil Law Act 1956, the pre-amendment provisions apply with regards loss of earnings. Therefore, 55 years of age is not the cut off point. However, being a lady, the plaintiff's working life would be until the age of 50

years. At the time of the incident, the plaintiff was 24 years old thus leaving 26 years of working life. One third of this ought to be deducted for contingencies thereby leaving a balance of 20 years. At the time of the incident, the plaintiff was earning RM440 a month. Taking into account the possibility of salary increments, RM650 is fixed as the salary for pre-trial loss and the direct multiplier method is used to determine the pre-trial loss. As for the post-trial period, RM800 a month is fixed as the plaintiff's salary. The total post-trial loss is calculated based on the actuarial basis. EPF contributions is also calculated based on the figures fixed.

**[7c]** The sum of RM500 for nursing care claimed is on the high side considering that loss of earnings has been awarded and the cost of employing maids. For the first ten years of the pre-trial period, RM350 is fixed as the cost of employing a maid while for the next five years of that period, RM500 is fixed. For the post-trial period of the remaining five years, RM500 is fixed as the cost of employing a maid.

*[Defendants 100% liable for plaintiff's injuries; damages ordered accordingly.]*

**Case(s) referred to:**

*Bolam v. Friern Hospital Management Committee [1957] 2 All ER 118* ***(refd)***
*Cassidy v. Ministry of Health [1951] 1 All ER 574* ***(refd)***
*Christopher Rogers v. Maree Lynette Whitaker [1993] 1 CLJ 449* ***(refd)***
*Kow Nan Seng v. Nagamah & Ors [1982] 1 MLJ 128* ***(refd)***
*Tan Ah Kau v. The Government of Malaysia [1997] 2 CLJ Supp 168* ***(refd)***
*Whitehouse v. Jordan & Anor 1 BMLR 14* ***(refd)***
*Wong Fook & Anor v. Abdul Shukur Abdul Halim [1990] 2 CLJ 382* ***(refd)***
*Yeap Cheng Hock v. Kajima-Taisei Joint Venture [1973] 1 MLJ 230* ***(refd)***

**Legislation referred to:**

Rules of the High Court 1980, O. 59 r. 19(1)

*For the plaintiff - Dato' RK Nathan (Victoria Martin with him); M/s RK Nathan & Co*
*For the 1st defendant - Ajit Kumar (GL Ambrose with him); M/s Chooi & Co*
*For the 2nd defendant - PS Ranjan (MS Dhillon & EG Chew with him); PS Ranjan & Co*

*Reported by Izzaty Izzuddin*

**JUDGMENT**

**Mokhtar Sidin JCA:**

This is a claim by the plaintiff against both defendants for medical negligence. This was as a result of the treatment given by Dr. Soo Fook Mun (hereinafter referred to as the "2nd defendant") at the Assunta Hospital (hereinafter referred to as "the hospital"). The plaintiff went into the hospital after the car she was in was involved in an accident somewhere near the hospital. The undisputed facts in respect of this case is that at the time of the accident the plaintiff was 24 years. She was a young woman gainfully employed as a clerk-cum-typist. On the late evening of 11 July 1982 she, her boyfriend and two others went for supper in a car driven by her boyfriend. It was after 10pm. The plaintiff was seated in the front passenger seat. The car then collided into a tree. After the collision the plaintiff immediately alighted from the car and assisted the driver and his sister out of the car. She then shouted for help and some people from a nearby mosque came to her aid. All three were then sent to the hospital in another car. At the entrance to the hospital, the plaintiff on her own alighted from the car and walked unassisted into the emergency room. She was admitted and a series of x-rays were then taken after which she was warded. At that time she was able to move her body and limbs though she felt some pains at the neck.

In her evidence the plaintiff stated that when the x-rays were taken and on admission she was able to move her limbs. Further in her evidence she said that from 12.01am until 8am on 12 July 1982 the 2nd defendant did not come and see her. The 2nd defendant came to see her only on Monday afternoon (12 July) or the next morning. Finally when the 2nd defendant came and examined her, she was told that she had suffered dislocation on two of her neck bones. He also told the plaintiff that injury was a small problem and asked her to rest in bed. It is clear from the evidence that at that material time the plaintiff was able to move her body and limbs. The plaintiff had to wear cervical collar in order to contain the neck pain. The 2nd defendant ordered traction to be done on the plaintiff, *ie*, by placing a strip under her chin and pulling her neck backwards with weights attached. This treatment was carried out for two days. When the treatment was done the plaintiff was conscious and able to move her body and limbs. The 2nd defendant stopped this treatment after two days when he decided that it was unsuccessful. The 2nd defendant then tried close manipulation under anaesthetic and again this was unsuccessful. On that failure the 2nd defendant then recommended surgery (open reduction). It is clear that the evidence up to that stage was accepted by both sides except that the plaintiff disputed the time taken for traction treatment was too short and that was why there was no effect. It is clear to

me that at the time just before the surgery the plaintiff was not paralysed because she was still able to move her body and limbs. The surgery was the beginning of the problems leading to this suit. It was the contention of the plaintiff that when the 2nd defendant did the surgery he was negligent which caused the paralysis on her.

In his evidence the 2nd defendant stated that at about 1.30am on 12 July 1982 while he was in his house, Dr. Celine Pereira informed him that the plaintiff was admitted to the hospital with fractured cervical spine and there was also a query of an intra abdominal injury. Dr. Pereira diagnosed this after checking the x-ray. The 2nd defendant was of the opinion that a dislocated facet was more serious than fractured cervical spine. After examining the plaintiff, the 2nd defendant discovered that the plaintiff was suffering from dislocated facets. As such the diagnosis given by Dr. Pereira was wrong. In explaining this the 2nd defendant said that the mistake was made because Dr. Pereira was not conversant with injuries to cervical spine. It is difficult for me to accept this explanation because it is clear to me that Dr. Pereira was a well qualified doctor who would be able to read an x-ray and tell the difference between fracture and dislocation. Further, Dr. Pereira was not called to give evidence and it is unfair for the 2nd defendant to say what he said. From the evidence of the 2nd defendant himself, I am of the view that Dr. Pereira had given the correct diagnosis of the injury suffered by the plaintiff. Firstly, based on the evidence of the 2nd defendant that dislocated facets was more serious, Dr. Pereira took the trouble to call the 2nd defendant at about 1.30am to show that she knew the seriousness and the urgency of the plaintiff's injury. Secondly, the preventive measures of putting cervical collar on the plaintiff's neck and placing sandbags on the bed to minimise movements as instructed by the 2nd defendant show the injury suffered by the plaintiff was one of dislocated facets. The reason for the 2nd defendant for saying that the mistake made by Dr. Pereira was an excuse for not attending to the plaintiff immediately.

The plaintiff admitted that the 2nd defendant did recommend surgery when the treatments stated above failed. In her evidence she said that the 2nd defendant recommended the surgery but did not explain the risks of the surgery. She also said that she did ask the 2nd defendant of the procedure and the risks, to be more specific the dangers of the surgery and if anything untowards could happen to her. She said the 2nd defendant assured her that the surgery would be a minor and simple one. She gave evidence that since the assurance was given she consented to the operation (hereinafter referred to as the "1st operation") which took place on 19 July 1982. She regained consciousness after the first operation at about 8pm and she felt weak and tired. She discovered that she was not able to move her body and limbs. She

shouted to the nurse who was in the ward to call the 2nd defendant, but the 2nd defendant did not come to see her that night. The following day the 2nd defendant came to see her and conducted reflex test on her. He assured the plaintiff that the paralysis was only temporary and that she would recover and able to move in two weeks. On 5 August 1982 (which was about two weeks after the 1st operation) one Dr. Mohandas, a neurosurgeon, came to see the plaintiff and Dr. Mohandas did a myelogram test on her. When this was done the 2nd defendant was also present. The 2nd defendant and Dr. Mohandas did not explain to the plaintiff why that test was carried out. After that she was taken to the operation theatre where another operation (hereinafter referred to as the "2nd operation") was performed. The plaintiff said that no one explained to her why the 2nd operation was necessary and that she did not give her consent to the 2nd operation. This issue of consent would be discussed later. The 2nd operation was performed by the 2nd defendant in the absence of Dr. Mohandas, the neurosurgeon. It is not clear whether there was any recommendation by Dr. Mohandas that he should be present when the 2nd operation was performed. Though there was evidence that Dr. Mohandas did prepare a report why the test was performed, that report was never produced in court. When the plaintiff regained consciousness after the 2nd operation she discovered that she was able to move her hands only. She could not move her legs. According to the plaintiff, the 2nd defendant assured her that her bones had been stabilised and that she would recover from the paralysis within a month. The plaintiff remained at the hospital for eleven months without recovering the use of her legs after which she discharged herself and admitted herself into Tung Shin Hospital.

In her evidence, the plaintiff said that she met Dr. Mohandas after she was discharged from the hospital. According to her, Dr. Mohandas explained to her that the wire which was placed to correct the dislocation of C4 and C5 vertebrae during the 1st operation was pressuring the spinal cord and that caused the total paralysis. This was discovered after he conducted the myelogram test. As a result of that the 2nd operation was necessary. At the request of the solicitors for the hospital. The plaintiff visited Dr. Mohandas to reassess her condition. This was after the filing of the present suit. The report of this reassessment by Dr. Mohandas was never produced. It was unfortunate that at the time of the trial Dr. Mohandas had passed away.

In the absence of Dr. Mohandas and the report, the court has to rely on the evidence of the plaintiff especially as to the reason why the 2nd operation was performed. According to the plaintiff the 2nd operation was necessary to remove the wire pressuring the spinal cord. This piece of evidence was not contradicted by the defendants.

At Tung Shin Hospital, the plaintiff was asked for the x-rays taken on her at the hospital. She then requested the hospital for the x-rays but the defendants especially the 2nd defendant refused to hand over the x-rays. The excuse given was that those x-rays were the only copies available and there was no technology to duplicate the x-rays. Those x-rays, purportedly to be in the possession of the defendants, were not produced in court just like the report of Dr. Mohandas. That being the case I have no alternative but to infer adversely against the defendants. The importance of this, will be reflected later.

It is the case of the defendants that the injuries suffered by the plaintiff came from the motor accident, *ie*, the neck pains, if unattended would lead to paralysis sooner or later and those were the reasons the 1st operation was performed on the plaintiff.

It is the case of the plaintiff that she did consent to the 1st operation. Though she gave her consent, she did not know the risks of that operation because the 2nd defendant did not explain them to her. She was told by the 2nd defendant that the operation was a minor and simple procedure and that was why she consented. Had she known that the 1st operation was a major surgery with high risks she would not have consented. For the 2nd operation she maintained that she did not consent and she did not know the purpose of the operation.

The 2nd defendant raised the issue that the plaintiff had consented to the operations and as such the 2nd defendant should not be blamed that something had gone wrong during the operations. At p. 12 of exh. P2 the purported consent letter was exhibited which was worded as follows:

> I, FOO FIO NA hereby give my consent for any operation or anaesthetic which the Medical Officer may consider necessary on myself and understand an assurance has not been given that a particular surgeon will perform the operation.
>
> Witness: S/N Chuah Date 5.8.82
>
> Signed: (Plaintiff's right thumb)

Plaintiff denied that she gave the consent for the 2nd defendant to perform the operation. Evidence was adduced by the defendants that when the plaintiff was admitted to the hospital she was asked to sign a consent form. For that purpose it is only proper for me to see the contents in the admission form which are as follows:

HOSPITAL ASSUNTA
PETALING JAYA

ADMISSION FORM

Name: FOO FIO NA Hospital No: 5493763

Blood Group: Date of Birth: 24 yrs Sex: F

Address: 22 Road 37, O.U.G., K.L.

Occupation: Gen. Clerk Service: i.e. Medical, surgical, paediatrics

Employer's Name
and Address: Juru Tamu Sdn. Bhd.

Ward: Surgical Date of Admission: 12.7.92 Time:

Consultant:

Transferred from: To:

Religion: Christian Race: Chinese Maritial Status: S

Referred by: I.C. No. 5493763

Destination in discharge: Discharged: 20.4.83 Time: pm

Next of Kin: Name: Gordon Foo Relationship: Brother

Address: 40 Jalan SS14/3B, Subang Jaya Tel No. 569711 (O)
710213 (H)

I, FOO FIO NA hereby give my consent for any operation or anaesthetic which the Medical Officer may consider necessary on myself and understand an assurance has not been given that a particular surgeon will perform the operation.

Witness: S/N Kong Date: 13.7.82 Signed: Foo Fio Na
S/N Kaur Date: 15.7.82 Signed: Fio Na Foo

This is to certify that I, am taking my departure from the Hospital at my own risk and against the advice of the Medical Officer.

Witness Date: Signed:

I, Foo Fio Na hereby agree to my treatment (Lumbar Puncture), medication and such diagnostic procedures as the Doctor in attendance deems necessary for myself during treatment in this Hospital.

Signed: (Thumb print) Date:

Admitted by Dr. Celine (SR Khoo)

| Final Diagnosis: | Code: | Date and Nature of Operation: | Code: |
|---|---|---|---|
| Primary | | 14/7 | Attempted MUA of Servical Spine |
| Secondary & | | 19/7/82 | Open reduction, gallies wire Posterior or spinal fusion |
| | | 5/8/82 | Re exploration, removal of wire and Rt. Laminotomy |

From the above, I agree with the plaintiff's counsel that any patient admitted into the hospital had to fill up this form and sign it. This was the standard admission form which every patient should fill and sign. In that form there was already the standard stipulated consent given by the patient. It was contended by counsel for the plaintiff the general consent contained in the admission form was not sufficient to admonish the duty of the defendants to get the consent of the plaintiff unless it could be shown the plaintiff was given the explanation why the operation was necessary and the risks of that operation. Since the plaintiff in her evidence had stated that she was not told the nature of the operation and its risks, the onus now shifts to the defendants to show to the court that they had explained the necessity and the risks to the plaintiff. The defendants did not call any witness to testify to this. It is obvious to me that they could not do so because the consent as stated above was given on 13 July 1982 (the date stated in the admission form). On that date it was not known whether there was any necessity for the plaintiff to undergo an operation because the progress of the conservative treatments was not known. The operation was carried out after conservative treatments had failed. As such it is clear to me that when the consent in the above-stated form was given it was not known whether the plaintiff needed the operation and what sort of operation it would be. It could also be concluded that at the time when that consent was signed both defendants did not know whether the plaintiff really needed the operation. As such I am of the view that it would not be possible for the 2nd defendant to explain the procedure and the risks of the operation when the consent in the above-stated form was given or signed. For that reason I believe the plaintiff when she said that the 2nd defendant told her that the 1st operation (open reduction) which took place on 19 July 1982 was a minor operation to correct the little problem of the neck that she was suffering. In other words she was not told of the risk of paralysis coming from that operation.

I now turn to the second consent which is at p. 12 of exh. P2 which is worded as follows:

> I, FOO FIO NA hereby give my consent for any operation or anaesthetic which the Medical Officer may consider necessary on myself and understand an assurance has not been given that a particular surgeon will perform the operation.
>
> Witness: S/N Chuah Date 5.8.82
>
> Signed: (Plaintiff's right thumb)
>
> (Emphasis made)

As can be seen this consent was dated 5 August 1982 which was after the 1st operation and she became totally paralysed in the limbs both upper and lower. That being the case the question of the plaintiff affixing her thumbprint on the consent form voluntarily, comes into play. Somebody had to do it for her. She could not have affixed by herself because she was not able to move her hands and neither could she resist the affixing of it if someone did it for her. She gave evidence that she did not consent to the second operation. The burden is on the defendants to satisfy the court that the consent given was voluntary. It is clear to me that the affixing of the thumbprint was not done in the presence of a relative or a friend of the plaintiff. The 2nd defendant and the staff of the hospital knew of the existence of the brother of the plaintiff and her friend and yet they affixed the thumbprint in their absence. I could not understand the haste in doing that because the plaintiff was already paralysed for two weeks and that she was an invalid. They could easily inform the brother and the friend to witness the affixing to signify the voluntariness of affixing the thumbprint. The defendants ignored this simple procedure and they had to pay the price of ignoring it when the plaintiff denied giving her consent voluntarily.

As to the issue on consent I need to refer to a recent decision of *Tan Ah Kau v. The Government of Malaysia* [1997] 2 CLJ Supp 168 where Low Hop Bing, J. at pp. 185 - 188 said:

> It is the plaintiff's case that the consent was not or not adequately explained by the defendant's agents or servants to the plaintiff. The defendant submitted that the consent was indeed explained and interpreted to the plaintiff.
>
> In my judgment, the issue of the defendant's liability may be established by the fact that the plaintiff has not given his consent to the operation and that consent (even if it had been given) had not been fully explained to the plaintiff in order to enable him to understand the nature and consequences of the consent in relation to the operation and the diagnosis.

> The plaintiff maintained that he signed two blank forms at the same time and he was never explained before the operation. He signed a blank form for the myelogram and was never explained the reason by the doctor. Plaintiff was told that if he was not operated on, he would not be able to walk in the future. He was told by the doctor that two weeks after the operation, he would find relief from pain and that was why he consented. ...
>
> The question for the Court to decide is whether, at the time the plaintiff signed the consent forms, the plaintiff understood the nature and consequences of the consent and whether the plaintiff knew the subject matter which was central to his consent, in the light of the evidence that " ... most patients opt out when the complications are explained to the patient ....
>
> In *Christopher Rogers v. Maree Lynette Whitaker* [1993] 1 CLJ 451, the Australian High Court (the highest Court in Australia) held, *inter alia,* that:
>
> > ... It is the duty of a doctor to warn the patient of any material risk, particularly if the patient, if warned of the risk, considers it to be significant ... A risk which entails a duty to warn is one which is foreseeable and real but not one which is "far-fetched or fanciful.
>
> In the instant case, where the risk of paralysis was very real, more so when the tumour was intramedullary, it is absolutely essential for the attending surgeon such as DW1 or any doctor assisting him to warn the patient of the foreseeable risk of even a finding of intramedullary tumour. The duty to warn the patient arises here because the risk is both real and foreseeable, as was admitted by the defence expert DW6. ...

Similar factual situations existed in the present case. It is significant to note that the plaintiff gave evidence that when she was asked to sign some papers for admission she was also signing the consent to an operation without her in fact knowing it.

According to the evidence when she signed the consent she did not know that she needed the operation on the spinal cord. Even assuming that she needed the operation she was not told that it would be a major one which might lead to paralysis. Before the operation she was told and assured by the 2nd defendant that the operation was only a minor one. The reason and the procedure were never told to the plaintiff by the 2nd defendant. The failure to do so and the misrepresentation by the 2nd defendant that it was a minor operation clearly shows that the plaintiff would not consent to such an operation and the consent, if any, was not obtained properly.

As to the 1st operation, it is clear to me that the 2nd defendant had done something which caused the paralysis. I am satisfied that the paralysis was caused by the wire loop compressing the spinal cord and when the wire loop was removed during the 2nd operation the plaintiff was able to move her upper

limbs. It does not matter what explanation the 2nd defendant gave for removing the wire loop because the fact remained that the plaintiff recovered the use of her upper limbs after the removal of the wire loop. The wire loop inserted by the 2nd defendant during the 1st operation was the cause of the paralysis. The 2nd defendant was again negligent when he did not take any step to remedy the paralysis immediately. Instead he waited for two weeks to do the remedial operation and all that time he kept on assuring the plaintiff that she would recover from the paralysis which was only temporary in nature. In my view the above shows that the 2nd defendant failed to exercise the care and skill of an ordinary competent practitioner in that profession as stated by the Federal Court in the case of *Kow Nan Seng v. Nagamah & Ors* [1982] 1 MLJ 128.

From the evidence before me, it is clear to me that something had gone wrong when the 2nd defendant performed the 1st operation whereby the plaintiff suffered total paralysis. The 2nd operation was performed to ratify this whereby the plaintiff recovered the use of her upper limbs. It is also clear to me that the plaintiff was not paralysed before the 1st operation.

The main evidence of the defence came from the 2nd defendant. The 2nd defendant gave evidence that he was a visiting consultant to the hospital at the material time. He admitted that he was informed of the plaintiff at about 1.30am on 12 July 1982 by Dr. Celine Pereira who had called him in the house. He instructed Dr. Celine to place cervical collar around the plaintiff's neck and to use sandbags to minimise the head movements. He saw the plaintiff at about 8.30am that day. It is obvious to me that when the 2nd defendant was informed by Dr. Celine about the plaintiff at about 1.30am., the plaintiff's case was considered serious, otherwise there was no necessity for Dr. Celine to call the 2nd defendant who was only a visiting consultant at that hour. The 2nd defendant instead of coming immediately to examine the plaintiff merely gave oral instructions to Dr. Celine. When the 2nd defendant did not attend immediately to the plaintiff and only gave oral instructions by phone to Dr. Celine it shows the attitude of the 2nd defendant which in my view tantamounts to negligence. After examining the plaintiff, the 2nd defendant told the plaintiff that she had dislocation of C4 and C5 vertebrae with laterally locked facets. He found that this was uncommon and serious, as it was a matter of time before she would become paralysed. Thus in his own words the 2nd defendant admitted that the plaintiff's condition was serious and yet he took his own sweet time to attend to the plaintiff. He said that he explained to the plaintiff the possibility of paralysis and that it was important to have the dislocated vertebrae reduced to restore the normal diameter of the spinal canal. Obviously, as I have stated earlier, the plaintiff denied this and on the other hand maintained the 2nd defendant told her that her condition was a small problem.

The 2nd defendant also gave evidence that since the dislocation was not reduced 24 hours after the traction treatment, he was of the opinion that treatment failed. He then did a close manipulation under general anaesthesia to unlock the locked facet joints. Three attempts were made and according to the 2nd defendant, all those attempts failed. The 2nd defendant then recommended open reduction to the plaintiff. He gave evidence that he told the plaintiff the purpose of this treatment which was to retain the reduction by wiring and bone grafting and that there was a risk of paralysis. The plaintiff admitted that she was informed of the purpose of the treatment but denied that the 2nd defendant told her of the risk. Instead, she said that the 2nd defendant informed her the treatment was a simple and minor operation. For the reason she gave her consent to the treatment. It was common ground that the 1st operation was performed on 19 July 1982.

When the 1st operation was performed, other than the plaintiff and the 2nd defendant, only Dr. Sushila Nair, the anaesthetist, was present. She gave evidence that it was her duty to administer the anaesthetic and to monitor the plaintiff's vital signs during the 1st operation. She also said that if there was slow compression of the cord she would not be able to tell through the pulse rate reading. That was all she could tell about the 1st operation. It appears to me that she did not know what the 2nd defendant did during the 1st operation. The 2nd defendant in his evidence stated that during the 1st operation he used periosteal elevator to lever the dislocated vertebrae into their original position. A loop of wire was then passed sublaminar on C4, hugging the bone very closely. He then tightened and looped the loop around the spinus process of C5. He then knotted the wire. He stated further that an x-ray was taken of the neck bones and the x-ray showed that the dislocated C4 and C5 vertebrae was reduce and that the wire was not in the spinal cord. He then did bone grafts which were taken from the hip bone and placed at the cervical vertebrae from C3 to C6. He said at no time the wire was compressing the spinal cord and that the first time he heard about it was in court. The x-ray mentioned by the 2nd defendant was never produced in court despite requests being made by the plaintiff for the x-ray and also for it to be produced in court. Its whereabouts is still a mystery until today. From the evidence of the 2nd defendant it is clear to me that that x-ray is of vital importance to both sides especially the plaintiff. In my view that x-ray would help the court to determine whether the wire loop pressured the spinal cord. It is alleged by the plaintiff through other evidence that the wire loop touched the spinal cord. The production of that x-ray would be able to help the 2nd defendant to negate the allegations by the plaintiff.

It is pertinent for me at this stage to touch on the x-rays. Mr. Stephen Wong, the hospital's medical records officer, told the court that one Dr. C.N. Chew, on behalf of the plaintiff, requested for the x-rays taken on the plaintiff. That request was referred to the 2nd defendant. This was done on specific instructions of the 2nd defendant. He sent the request and the x-rays to the 2nd defendant. He did not know what happened to the x-rays after that. He was not sure whether they were returned to the records office or whether they remained in the possession of the 2nd defendant. The 2nd defendant admitted that he did receive the request by Dr. Chew from Mr. Stephen Wong together with the x-rays. He said he handed the x-rays to a man purportedly to be the representative of the plaintiff to be handed over to Dr. Chew. He said he could not remember the name of the man and he did not record it anywhere the name of the man who took the x-rays or obtained any acknowledgement for that. It is clear Dr. Chew never received those x-rays. By then the 2nd defendant knew that there was a medico-legal case pending. It appears to me that it was unlikely he did what he said he did. In my view he never handed those x-rays to the man. If it is true then by his action it showed that he was already negligent in handing over those important documents to an unknown person.

Sensing that the court might not believe his story on the x-rays the 2nd defendant then changed his story and gave evidence that those x-rays could not be found. To strengthen his story the 2nd defendant gave evidence that the x-rays were vital to his defence. As I have said earlier, the x-rays were also vital to the plaintiff. From the evidence and the record available it is clear to me that the last person to handle the x-rays was the 2nd defendant. There was clear evidence to show and it was recorded that Mr. Stephen Wong handed those x-rays to the 2nd defendant after the request by Dr. Chew for them. Though the 2nd defendant said that he handed those x-rays to the records office, there was no evidence ever recorded that this was done. As I have said earlier it is clear the x-rays were never given to Dr. Chew. Both defendants told the court they could not trace the x-rays when the records office of the hospital moved and might had been misplaced. In my view, taking into consideration the reputation of the efficiency of the hospital and the importance of those x-rays to the defence, this story was very unlikely. Having heard the evidence, I could not help but infer that the x-rays were in the possession of the 2nd defendant since they were given to him by Mr. Stephen Wong after the request by Dr. Chew. In my view the defendants (especially the 2nd defendant) did not produce those x-rays because they were not favourable to them. After hearing the evidence, it is not wrong for me to conclude that the x-rays were in the possession of the 2nd defendant and there was no record of x-rays being returned to the records office.

As I have said earlier, the plaintiff in her evidence said that Dr. Mohandas, the neurosurgeon, told her that after seeing the x-rays and after conducting the myelogram test, Dr. Mohandas recommended that a second operation be done on the plaintiff. He made this recommendation after he found the wire loop was pressuring the spinal cord. It is clear to me that Dr. Mohandas would not be able to know unless he had seen the x-rays. On seeing this he did a myelogram test which confirmed his findings. He then recommended a second operation to be performed immediately on the plaintiff to remove the wire loop. The 2nd defendant complied with this and after the 2nd operation the plaintiff recovered partial movements of her limbs. This evidence lend credentials to the evidence of the plaintiff. That shows how important those x-rays to the plaintiff.

In view of the unsatisfactory explanation of the non-production of those x-rays in court by the defendants I have no alternative but to invoke s. 114(g) against the defendants. They were never produced in court although counsel for the plaintiff requested for them to be produced. Weight should not be given to the explanation by the 2nd defendant that his understanding of the medico-legal case was that of the motor accident because it is clear to me that whether it is a motor accident case or a medical negligence case those x-rays were needed by the plaintiff.

The 2nd defendant adduced evidence that the procedure that he had adopted was the correct procedure. He gave evidence that after the 1st operation the vital signs on the plaintiff were steady and the function of the spinal cord was normal. He said that in the recovery room he had asked the plaintiff to move the upper and lower limbs which she did. He also conducted normal testing on sensation. The plaintiff, however, denied this. In her evidence she said that she was very weak when she regained consciousness. She then discovered that she was not able to move her limbs. She shouted to the nurse on duty to call the 2nd defendant who did not attend to her immediately. It is obvious to me there is direct conflict between the evidence of the 2nd defendant and the plaintiff in that the 2nd defendant said that the plaintiff was not paralysed immediately after the 1st operation whereas the plaintiff said she was. I tend to believe the plaintiff because it was not possible for her to move her limbs when she was unconscious. The 2nd defendant said that he conducted the test on the plaintiff when she was in the recovery room which means that she was still unconscious or very groggy. The plaintiff herself gave evidence that when she regained consciousness the 2nd defendant was not there. She then discovered that she could not move her limbs and then she shouted to the nurse to call the 2nd defendant. The plaintiff gave evidence that from the time she regained consciousness after the 1st operation until the 2nd operation she was not able to move her limbs. There was no evidence to show

otherwise. The 2nd defendant admitted that he did not record in the case notes or anywhere else what transpired from the time the plaintiff was under anaesthetic until she regained consciousness. It is clear from the evidence the plaintiff was totally paralysed after the 1st operation. The defendants did not dispute that the plaintiff was paralysed after the 1st operation, the only dispute was when did the paralysis begin? From the evidence, I am of the view that the paralysis occurred after the 1st operation until the plaintiff regained consciousness which was within twelve hours after the 1st operation. The issue was whether the paralysis was caused by the 1st operation. This was also confirmed by the evidence that the wire loop placed by the 2nd defendant during the 1st operation which pressured the spinal cord. Was the treatment and the 1st operation conducted by the 2nd defendant the normal practice in treating the plaintiff?

For this the plaintiff and the 2nd defendant called an expert witness each to testify. The plaintiff called Dato' Dr. Arumugasamy to testify on her behalf. In his evidence Dr. Arumugasamy said in a case such as the plaintiff's he would have proceeded with conservative treatments first before proceeding with the open reduction. By conservative treatments he meant traction and wearing of cervical collar on the neck to reduce the pain. He gave evidence that the conservative treatments would take some time before they could produce any result and have any effect. This could not be done two or three times or within one or two days. The traction should be carried out for sometime and could be extended for months. The 2nd defendant admitted that the traction treatment could be extended for three months depending on the response of the patient. Dr. Arumugasamy gave evidence that the plaintiff was able to move when she was admitted and she complained only of the pains in the neck. In such a situation, he would proceed with conservative treatments first. The time taken for such treatments would depend on the response of the patient. It would take a couple of days or months before it could be concluded that the patient is not responding to those treatments. If the patient responded immediately, then the time taken for the treatments would be shortened and the treatments should be discontinued as soon as the patient recovered. Dr. Arumugasamy was of the opinion that the time taken by the 2nd defendant in administering the conservative treatments which was only for two days would not be sufficient to determine whether the plaintiff was responding to the treatments or not. He went on to say that the conservative treatments would be prolonged before it could clearly be concluded that the plaintiff was responding to the conservative treatments or not.

Dr. Myles Gibson, a neurosurgeon from the United Kingdom, was called by the 2nd defendant to give evidence as an expert witness on his behalf. In his evidence, Dr. Myles Gibson described that the dislocation of C4 and C5

vertebrae with bilaterally locked facets as the whipping movements which resulted in the jumping of the facets one over the other and the forward movement of the upper vertebrata upon the lower. He was of the opinion that if this was left untreated, the plaintiff would have developed progressive weakness of all four limbs and ultimately she would have sustained paralysis of all the limbs. This so called expert witness was asked by the 2nd defendant to contradict Dr. Arumugasamy's evidence. With the greatest respect I am of the view that he did not do so. This witness gave evidence what would be the effect if the injury was left untreated. Dr. Myles Gibson did not specifically state when the paralysis would set in in the case of the plaintiff. It could be months or years later but one thing is certain that it would not occur immediately after the motor accident. On the other hand, Dr. Arumugasamy gave evidence that the condition of the plaintiff if untreated would remain the same unless she does headstand. The only thing she would suffer is the pains.

Dr. Arumugasamy gave his evidence after examining the plaintiff and caused x-rays to be taken on her. He also looked into the case notes of the plaintiff. Dr. Myles Gibson, in his evidence, admitted that he did not see or examine the plaintiff though she was available nor did he see the x-rays of the plaintiff. He also admitted that he formed his opinion after he saw the case notes of the plaintiff given to him by the 2nd defendant. He further admitted that he prepared his opinion in the office of the solicitors for the 2nd defendant after Dr. Arumugasamy had given his evidence and the notes of proceedings were with the solicitors. I was amazed and appalled with the admissions by Dr. Gibson because I am of the view that a doctor could not give any opinion what more an expert opinion as to the injury of any person without seeing and examining that person and also in the present case without seeing the x-rays of that person. His expert opinion was based entirely on the case notes given to him by the 2nd defendant which had been shown to be suspected. It was not proven in court that the case notes given to him was the one produced in court. This led me to comment we in Malaysia are not living in the jungle anymore whereby an opinion by a white man is to be accepted as expert opinion and the only opinion to be accepted.

Dr. Myles Gibson himself admitted in evidence that if the case notes given to him were incorrect or had been tampered with, then his opinion would be wrong. The plaintiff had succeeded in showing that several entries in the case notes had been altered or tampered with and as such they were suspected especially in material entries such as laminotomy or laminectomy and when the discovery of the paralysis. The plaintiff had succeeded in showing the case notes had been altered or tampered. It is to be noted that the plaintiff had succeeded in establishing that Dr. Gibson at the material time when he gave evidence in court was a council member of the Medical Protection Society which is established to protect any undoing or negligence of a member. The 2nd

defendant was a member of that society. As such Dr. Gibson's evidence is self-serving on the society which has interest in the decision to favour the 2nd defendant. As such his evidence could not be relied upon as what had been stated by Lord Wilberforce in *Whitehouse v. Jordan & Anor* 1 BMLR 14 at p. 24:

> While some degree of consultation between experts and legal advisers is entirely proper, it is necessary that expert evidence presented to the court should be, and should be seen to be independent product of the expert, uninfluenced as to form or content by the exigencies of litigation. To the extent that it is not, the evidence is likely to be not only incorrect but self defeating.

It is clear to me the report prepared by Dr. Gibson was done solely to counter the evidence of Dr. Arumugasamy and not an independent and neutral opinion of the patient.

After hearing the evidence of Dr. Arumugasamy and Dr. Gibson, I am of the opinion that the evidence of Dr. Arumugasamy is more reliable. His evidence shows that the 2nd defendant had committed an error when the first operation took place which caused the paralysis. This was confirmed by the 2nd operation when the wire loop was removed and the plaintiff was able to move her upper limbs. To me there is clear evidence that the wire loop which compressed the spinal cord caused the paralysis. Though the plaintiff was able to more her upper limbs, the paralysis in the lower limbs persisted.

During the trial, counsel for the plaintiff produced a passage from Campbell's Operative Orthopaedics (p. 3123 of exh. P12) and showed it to the 2nd defendant. In that it was stated that the normal practice of using the periosteal elevator, there must be traction constantly asserted to the head. The 2nd defendant agreed with that passage except for "traction be constantly asserted" where he said that the suggestion by the book on that was a controversial one. The 2nd defendant did not dispute that the text is a leading write-up on orthopaedics and he was not able to show any other authoritative book which contradicts that suggestion in exh. P12.

The 2nd defendant was shown another book entitled "manual of internal fixation" (Exh. P17) in particular a passage at pp. 627 - 628 where it was stated that in a case of paralysis occurring immediately after surgery an immediate re-surgery ought to be done. While agreeing with the recommendation made by the book, the 2nd defendant stated that the recommendation was not found in the 1979 edition of the same book which he said was in his possession. He was given time to produce that edition but was not able to do so. As such there was no way to verify what he had said. It is the submission of the learned counsel for the plaintiff that that is the standard procedure and this passage appeared in every edition of the said manual.

Despite discovering that the plaintiff was paralysed when the 2nd defendant visited her on 20 July 1982, the 2nd defendant did nothing until 27 July 1982 (about seven days later) when he did lumbar puncture on the plaintiff to find out whether there was any compression on the spinal cord. I could not understand why he did the lumbar puncture when he gave evidence that he was sure that the wire did not compress the spinal cord and he had double checked it by viewing the missing x-rays. The only explanation as I see it was that the 2nd defendant knew or had an inkling that the wire loop was compressing the spinal cord. On 29 July 1982 the 2nd defendant discovered that the plaintiff had developed spasms of the muscle on the lower limbs and the paralysis worsened. Further she had developed ankle clonus. He admitted that the spasm of the muscles were severe. The 2nd defendant gave evidence that on 2 August 1982 there were some suggestions of improvement but there was none on 3 August 1982 and 4 August 1982. In my opinion this could not be true because the plaintiff was already paralysed from 20 July 1982. On 3 August 1982 the 2nd defendant contacted Dr. Mohandas, the neurosurgeon, to do a cervical myelogram on the plaintiff. After the myelogram test was done, Dr. Mohandas told the 2nd defendant that there was a complete blockage of flow of dye at C4. Dr. Mohandas suggested to the 2nd defendant to re-explore to find out the cause of the blockage. It is to be noted that the 2nd defendant took two weeks to consult the neurosurgeon after he had discovered the plaintiff had suffered paralysis. He did not give any reason for the delay.

The 2nd defendant admitted that he did consider a need for a myelogram test before doing the close and open reduction but he did not do so. His explanation for not doing it was because he wanted to exclude prolapsed disc. He was of the view that normally such injury suffered by the plaintiff after the motor accident would be accompanied by prolapsed disc. Despite its importance he chose not to record it in his case notes. It is clear from the evidence that the myelogram was only done after the plaintiff was referred to Dr. Mohandas and Dr. Mohandas did the test. In my view the myelogram never crossed the 2nd defendant's mind until it was done by Dr. Mohandas. Had the 2nd defendant done the test before the 1st operation he would have discovered that the 1st operation would not be necessary or that the operation needed to be done by a specialist. The 2nd defendant was in such a hurry to do the open reduction without going into the necessary tests to determine the internal injuries of the plaintiff. The open reduction caused the paralysis which the plaintiff is now suffering.

As to the re-exploration (2nd operation) it is clear to me that it was done on the recommendation of Dr. Mohandas. Again this was done in haste without the presence of Dr. Mohandas, the consultant who would be able to assist or

guide him. I could not help but come to the conclusion that the 2nd defendant has something to hide from Dr. Mohandas.

In his evidence the 2nd defendant stated that during the 2nd operation he found the wire loop intact and not broken. He cut the wire and removed it so that he could do a laminotomy on the plaintiff. He maintained that without a laminotomy he could not inspect the cord thoroughly. Counsel for the plaintiff took up the issue whether the 2nd defendant did a laminotomy or a laminectomy. The issue came up when the case notes showed that the word laminotomy superimposed on the word laminectomy. The 2nd defendant in his evidence said that during the 2nd operation he found that the blockage discovered by Dr. Mohandas was due to the swelling of the spinal cord. Incidentally there was no evidence that Dr. Mohandas had said that there was a blockage and it was the evidence of the plaintiff that Dr. Mohandas had told her that the cause of the paralysis was the compression of the spinal cord by the wire loop placed by the 2nd defendant. The 2nd defendant went on to say the swelling was caused by the motor accident which dislocated the C4 and C5 vertebrae leading to a "kink" in the spinal cord. The "kink" had injured the spinal cord tissue which led to the swelling. He denied that the "kink" was caused by his treatment, namely the wire loop. He went on to say that he could not prevent the swelling because it was beyond his control. Since he had done a laminotomy on the C4 vertebra which had weakened, he did not re-insert the wire.

It is difficult for me to accept the evidence of the 2nd defendant on this because the evidence adduced in court showed there were no neurological deficits on the plaintiff after the motor accident. If the evidence of the 2nd defendant on this is true then the plaintiff would have suffered paralysis immediately or soon after that. It was not disputed that soon after the motor accident the plaintiff was able to walk and move around even though she was suffering some pains at the neck. Secondly, if the "kink" which is an uncommon occurence as admitted by him. The evidence and opinion of Dr. Arumugasamy on the "kink" was the result of the motor accident, the 2nd defendant would have discovered it during the 1st operation and he should have recorded the discovery in the case notes. It should be an important discovery. He himself admitted that if he had discovered any swelling he should have recorded it in the case notes and much so in the case of a "kink" which is an uncommon occurence as admitted by him. The evidence and opinion of Dr. Arumugasamy on the "kink" was not contradicted by cross-examination and as such his opinion should stand. The evidence of the 2nd defendant on the "kink" should therefore be rejected.

There are direct contradictions between the evidence of the plaintiff and the 2nd defendant as to when the paralysis first began. Plaintiff stated that the paralysis started when she regained consciousness after the 1st operation. The 2nd defendant gave evidence that the plaintiff complained of no feeling at about 8 or 9am in the morning after the operation, *ie*, 20 July 1982. He said that he had tested the plaintiff soon after the 1st operation for sensation and that she had responded to the test. The plaintiff gave evidence that when she regained consciousness after the 1st operation the 2nd defendant did not visit her at all that night or the early hours of 20 July 1982 indicating that the 2nd defendant could not have done the test just after she regained consciousness. There was no entry of the exact time as to the visit by the 2nd defendant on 20 July 1982 but there was an entry at 8am on 20 July 1982 in the case notes stating "sensation felt in all limbs". This contradicted the evidence of the plaintiff who said that when she regained consciousness after the 1st operation she could not move her limbs. Then there was a squeezed entry in the case notes at about 12 noon on the same date stating "patient can't feel any sensation at both legs". It is amazing that there were entries in the case notes of the sudden change of the condition of the plaintiff within a space of four hours.

During cross-examination the 2nd defendant stated that the squeezed entry was made by one of the nurses. Plaintiff in her evidence said the 2nd defendant did not come to see her at 8am on 20 July 1982 and that she complained about the paralysis to the nurse only at about 12 noon on the same date. As can be seen from the case notes all entries were in normal spacing and in sequence. The squeenzings were also done when there were scratchings. It appears to me those squeezings were done in order to favour the 2nd defendant. It is puzzling to me that an important discovery or complaint by a patient was only done by way of squeenzing. It is clear to me that all other entries made by the nurses in the case notes were meticulous indicating that the squeezed entry was an afterthought. There was another suspicious entry made by the 2nd defendant on 20 July 1982 stating "no feeling since this am. Immediately post-op she could move her upper and lower limbs and felt the pin pricks from the testing pin". This entry appears to me to be self-serving. After evaluating the evidence of the plaintiff and the 2nd defendant and also looking at the various entries in the case notes, I am inclined to believe the plaintiff when she said that when she regained consciousness after the 1st operation she discovered she could not move her limbs.

The contradictions, in my opinion, are not really material because the fact remained that the paralysis of the plaintiff occurred after the 1st operation.

The defendants called Theivani a/p Mudaliar (DW6) to give evidence. She was a staff nurse attached to the hospital at the material times. She was asked to explain the squeezed entries in the case notes which was to confirm what had been said by the 2nd defendant in respect of the squeezed entries. She admitted during cross-examination that she was not able to tell whether the plaintiff was awake between 8am to 12 noon on 20 July 1982. She confirmed that a patient had to be conscious in order to test her sensation. Yet there was a squeezed entry admitted to be done without any time and date but before the entry of 12noon on 20 July 1982 stating "sensation felt in all limbs". She agreed with counsel for the plaintiff that it was wrong for her not to record the time and the date of the entry in the case notes. After observing her when she gave evidence in court I found her to be evasive and not reliable. It is clear to me that the case notes had been tampered with by the squeezed notes and it was done to help the 2nd defendant.

As I have said earlier another issue taken up by counsel for the plaintiff during cross-examination of the 2nd defendant was whether the 2nd defendant did a laminectomy or a laminotomy on the plaintiff. A laminotomy is a process in making a window in the lamina of the vertebrae to inspect the spinal cord whereas a laminectomy is done for purposes of decompressing a mechanical compression on the spinal cord including a compression caused by a wire. The 2nd defendant was shown an entry at p. 162 of exh. P2 (the case notes) dated 5 August 1982 stating as follows:

> Am - myelogram done - have seen by Dr. Soo
> at x-ray department.
> For exploration of ...
> KIV laminectomy this ... pm

The 2nd defendant denied that he did a laminectomy on the plaintiff despite this entry. The 2nd defendant maintained that he only did a laminotomy and not a laminectomy on the plaintiff. There were other entries in the case notes showing the word "laminotomy" was superimposed the word "laminectomy" which had been covered by blanko. It occurred at several places in the case notes. The 2nd defendant's explanation was that he had given instructions to the nurses that he had done laminotomy and not laminectomy. Even with those instructions the nurses made mistakes or confused by writing the word laminectomy and not laminotomy. That was the reason for those corrections. The 2nd defendant was also shown an elaborate entry in the nurses' ward report dated 7 August 1982 showing that on 5 August 1982 the 2nd defendant did a re-exploration on the plaintiff whereby the wire was removed. This shows that a laminectomy was done. Though he admitted that the entry was correct, he still insisted that he had done a laminotomy and not a laminectomy. It is

difficult for me to accept the explanation given by the 2nd defendant especially when it is clear to me that the nurses employed by the hospital were well-trained and knew the medical terms used. Further, the explanation would be reasonable if the correction occurred only once, but this was done in almost all entries of the word "laminotomy".

Again, the 2nd defendant himself signed a request for a pathological specimen where the entry dated 7 August 1982 (page 88 of exh. P2) shows that a laminectomy was done on the plaintiff. This was never corrected even though he signed it. Viewing this as a whole I am of the opinion that the corrections were afterthoughts, after the 2nd defendant knew of an impending medico-legal case.

It was not disputed that the plaintiff was examined by Dr. Mohandas at the request of solicitors for the defendants and he had prepared a report of that examination. Defendants did not produce this report though counsel for the plaintiff had questioned the 2nd defendant on this and suggested that the report clearly stated that a laminectomy was done by the 2nd defendant. The 2nd defendant did not deny or produce the report to contradict the allegations by the plaintiff.

After considering the evidence of both the plaintiff and the 2nd defendant there is no doubt in my mind that the plaintiff's paralysis was caused by the 1st operation conducted by the 2nd defendant and not due to the motor accident. The 2nd defendant was negligent in tying the wire loop which caused compression to the spinal cord which led to the paralysis. The 2nd defendant was also negligent in not doing anything immediately after the discovery of the paralysis to remedy it. He was also negligent when he did the laminectomy (re-exploration) in the absence of the consultant who had pointed out the case of the paralysis.

Learned counsel for the hospital submitted that the plaintiff failed to establish negligence on the part of the hospital. It is true that there was no direct evidence of negligence per se against the hospital. In their defence the hospital denied that the 2nd defendant was their servant or agent. That being the case the hospital were not responsible for the negligent act of the 2nd defendant. On the other hand the plaintiff contended that the hospital were vicariously liable for the act of the 2nd defendant because the 2nd defendant was the servant or agent of the hospital. In my view the onus is on the plaintiff to prove that the 2nd defendant was the servant or agent of the hospital. The learned counsel for the plaintiff in his submission relied on the evidence of the 2nd defendant's statement of defence whereby the 2nd defendant pleaded and admitted that at all material times he was the servant or agent of the hospital.

The 2nd defendant in support of that evidence produced a letter dated 8 November 1984 (exh. D11). That was a letter of his resignation as an employee of the hospital. He admitted that he was employed by the hospital long before the incident. Even after his resignation his relationship with the hospital remained when he became a visiting consultant with the hospital. In their statement of defence the hospital did not deny that the 2nd defendant to be in their employment at the material times. The hospital did not adduce any evidence to show that the 2nd defendant was not their employee. It is clear to me at the material times the 2nd defendant was in the employment of the hospital. This was strengthened by the evidence of Dr. Nair, Ms. Theivani a/p Mudaliar and the operational manager of the hospital who had referred the 2nd defendant the staff of the hospital and had taken instructions from the 2nd defendant. In this respect I have only to refer to what had been said by Lord Denning in the case of *Cassidy v. Ministry of Health* [1951] 1 All ER 574:

> The liability of hospital authorities for the negligence of a doctor on the permanent staff of the hospital does not depend on whether he is employed under a contract of service or under a contract for services. It depends on who employs him. If the patient himself selects and employs the doctor, the hospital authorities are not liable for his negligence, but where the doctor, be he a consultant or not, is employed and paid, not by the patient, but by the hospital authorities, the hospital authorities are liable for his negligence in treating the patient.

In the present case here it is clear from the evidence that the plaintiff after the motor accident admitted herself into the hospital where she complained of pains at the neck. After the admission she was seen by one Dr. Pereira who informed the 2nd defendant of the injuries suffered by the plaintiff. The 2nd defendant then instructed Dr. Pereira what to do with the plaintiff. At that time the plaintiff did not know what she was suffering from nor did she request for the 2nd defendant to treat her. She sought treatment from the hospital. She filled up and signed the admission form. It is clear to me from the evidence that she was seeking treatment from the hospital and she would pay the fees, for the treatment that she had received, to the hospital. The 2nd defendant was assigned by the hospital to treat the plaintiff. Whatever payments to the 2nd defendant were made by the hospital as salary. There is no evidence that the plaintiff specifically requested or demanded that the 2nd defendant to treat her or that she promised to pay the 2nd defendant for his services. Whatever payments were to be made to the hospital and not to the 2nd defendant. In view of that it is clear to me that the 2nd defendant at the material times was a servant of the hospital. That being the case the hospital were vicariously liable for the wrongful act of the 2nd defendant.

It has been established in *Bolam v. Friern Hospital Management Committee* [1957] 2 All ER 118, the principle regarding a doctor's duty of care which was:

a (i) a doctor is not negligent, if he is acting in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, merely because there is a body of such opinion that takes a contrary view.

It is the plaintiff's case that she was not forewarned of her condition before b the 1st operation and she was not warned by the 2nd defendant of the possible residual defects, one of which was paralysis. Though disputed by the 2nd defendant, from the evidence adduced in court, I believe the plaintiff. Before conducting the 1st operation it is clear to me that the 2nd defendant did not do a thorough examination of the plaintiff to determine what caused the pains c to the plaintiff. Further, he did not conduct the conservative treatments properly and sufficiently before the 1st operation. It is clear from the evidence of Dr. Arumugasamy and the textbooks that the conservative treatments must be administered properly and carried on for a considerable period to produce any result. This appeared to me to be the normal practice. Furthermore, it is clear d from the evidence of Dr. Arumugasamy that there was no danger from the pains and the injuries suffered by the plaintiff that paralysis would set in immediately. According to him only headstand would cause paralysis. As such there is no necessity for the 2nd defendant to do the open reduction (1st operation) within such a short period. Dr. Gibson himself confirmed the view that paralysis would not set in immediately. As such the conservative e treatments should be continued for a considerable period which may be months and not within one or two days. It is clear to me that treatments conducted by the 2nd defendant was not normal. As I have said earlier, from the evidence I believe the plaintiff when she said the 2nd defendant told her that the 1st operation was a minor problem and he did not inform her of the risks of f paralysis. The 2nd defendant was negligent in not giving a proper warning to the plaintiff. The question of giving proper warning was further emphasized in the Australian case of *Christopher Rogers v. Maree Lynette Whitaker* [1993] 1 CLJ 449 where its highest court after having reviewed the *Bolam* test varied the said *Bolam's* principle when it said:

g This standard of skill is however not determined solely or primarily by the practice of the relevant profession or trade. Due consideration must also be given to the fact that a person is entitled to make his own decisions about his life. As regards the duty of disclosure of facts and risks involved, a patient is entitled to know what risks are involved in undergoing or foregoing the surgery h or other treatment. Whether or not a doctor is in breach of the requisite standard of care varies according to diagnosis, treatment or the provision of information or advice. It is the duty of a doctor to warn the patient of any material risk, particularly if the patient, if warned of the risk, considers it to be significant. In the present case, the risk is material. A risk which entails a duty to warn is one which is foreseeable and real but not one which is "far-i fetched or fanciful".

It is clear from the above that the principle underlying medical negligence cases is that the court itself has to decide on the doctor's negligence after weighing the standard of skills practiced by the relevant profession or trade and also the fact that a person is entitled to make his own decision on his life. What is expected of a doctor is that he has given a fair and reasonable standard of care and skill expected of an ordinary competent medical practitioner as held by the Federal Court in the case of *Kow Nan Seng v. Nagamah & Ors* [1982] 1 MLJ 128 where Salleh Abas, F.J. (as he then was), delivering the judgment of the court, at p. 130, said:

> There may be differences of opinion as to the types of plaster casts to be applied in the treatment of the type of injuries sustained by the respondent, but the choice of a treatment which is the standard medical practice is not by itself a negligence, *Bolam v. Friern Hospital Committee* and *Elizabeth Choo v. Government of Malaysia and Anor.* Thus the application of POP long boot to the respondent's left leg is not in itself a negligent act. However, since the application of POP carries with it and inherent danger of blood circulation, the question is whether there was fair and reasonable standard of care taken after POP was applied to see that there would be no problem of poor blood circulation. If there was such standard of care Dr. Susila and the Government would not be liable, but if there was not, they would be liable and the damages awarded should be apportioned.

Further down at p. 131 His Lordship said:

> Thus, in our view, the evidence in this case clearly shows that the respondent was not given fair and reasonable standard of care and skill expected of an ordinarily competent medical practitioner. The breach of care here consists of lack of proper skill in the application of the treatment and lack of proper observation in monitoring the patient's response to the treatment after it was given so that by the time the Hospital came to realise that something was wrong it was already too late. Malacca General Hospital tried to repair the damage done, but its effort was unsuccessful because the damage done was by then already beyond repair. It was on October 25 that the respondent most needed the care and attention and yet on that day nothing was done to his leg apart from a second x-ray. The claim that the two doctors were busy on that day because it was an operation day is not an excuse.

It is clear from the principle above that the determination of whether a doctor is negligent or not is for the court to determine based entirely on the evidence of each case. It is also clear from the authority that even though the normal or standard practice is followed a doctor may still be liable for negligence if something went wrong with the follow-up treatments such as lack of observations. In the present case the situation where the lack of due care commenced from the very beginning the plaintiff was admitted to the hospital until she was discharged from the hospital including immediate remedial treatments when it was discovered she suffered paralysis after the 1st operation showed the defendants were negligent.

It was submitted by both defendants that there was contributory liability on the part of the plaintiff. I am not really sure what the defendants meant because no evidence was adduced by the defendants leading to this. In my view the contributory meant by the defendants was the injury suffered by the plaintiff when she was admitted to the hospital. It was common ground that the plaintiff was suffering some pains at the neck when she was admitted. In the present case the claim by the plaintiff against the defendants was for the paralysis she had suffered because of the negligence of the 2nd defendant. Though the 2nd defendant attempted to show that the paralysis was caused by the treatment of the pains at the neck, the pains did not cause the paralysis. The 2nd defendant stated that he found locked facets of C4 and C5 vertabrae which may eventually lead to paralysis. First of all there was no evidence of the locked facets as alleged by the 2nd defendant. It was only his words. The x-rays which may help him were never produced. Secondly, his own expert witness did not positively say that this locked facets would definitely lead to paralysis. Thirdly, Dr. Arumugasamy, the expert witness for the plaintiff, was definite when he said the locked facets would not cause paralysis unless she does headstand. The only thing that she would suffer would be discomfort of pains in the neck. As I have stated earlier, from the evidence adduced, I found that the cause of the paralysis was the wire loop compressing the spinal cord. This wire loop was inserted by the 2nd defendant. It is clear to me that was the sole cause of the paralysis and nobody else contributed to it.

It was also suggested by the 2nd defendant that the plaintiff contributed to the state she is now when she discharged herself from the hospital. I could not understand how this could contribute to the sufferings she is having now. From the evidence it is clear to me that after the 2nd operation (re-exploration) the plaintiff remained at the hospital for eleven months. There was no evidence to show she had improved from the condition she had suffered after the 2nd operation. The defendants did not adduce any evidence to show her condition had improved or that she was likely to recover from that paralysis. She had no choice but to discharge herself and sought treatment from somewhere else. Even in this the defendants were of no help because when the other hospital requested for her case history especially in respect of the x-rays, this was refused. I do not know what the plaintiff could do anymore.

For the reasons I have stated above I could not find any contributory blame on the part of the plaintiff and as such I hold both the defendants to be 100 percent liable.

As for damages the parties submitted as follows:

**Damages**

***A. General Damages***

The plaintiff had sustained serious injuries and residuals. She is now a quadriplegic and is unable to do things on her own. Counsel for the plaintiff requested for RM200,000 as general damages. He cited *Wong Fook & Anor v. Abdul Shukur bin Abdul Halim [1990] 2 CLJ 382;* [1991] 1 MLJ 46 where for a quadriplegic plaintiff confined, like the plaintiff in this case, to a wheelchair, Abdul Malek J awarded RM180,000. Counsel for the 2nd defendant offered RM100,000 as general damages but no authority was cited.

In my view the amount to be awarded for general damages should be RM180,000.

***B. Special Damages***

With regard to her travelling expenses after the accident, she uses taxi to go to church, shop and visit friends and for all spends an average sum of RM100 per month and that is the amount she is claiming. I find the claim to be reasonable. She is also claiming for loss of contributions to the Employees Provident Fund (EPF) by her employers because she had to stop work due to her condition. I accept her evidence that she has to use diapers costing an average of RM100 per month as she has no control of her bladder. In addition to her claim for loss of earnings, she is also claiming RM500 as costs of nursing care because she cannot bathe, wash or dress herself. At the time when the case was heard she had Paul, a male friend , to help and assist her in her everyday chores.

***(i) Loss Of Earnings***

It is in evidence that the plaintiff passed her MCE in 1976 and that she started work when she was 18. She was working as a clerk-cum-typist before the unfortunate incident and was earning about RM440 a month and also contributed to the EPF. She was taking an advanced course in typing to advance herself in her career at the time of the incident. To establish her future earnings the plaintiff called the senior vice president who was also the principal of RIMA College (PW3) to give evidence on projectory income of a clerk-cum-typist. PW3 gave evidence that the income of a clerk-cum-typist with five years experience would be in the region of RM1,100 to RM1,300 a month whereas a company secretary's pay today is between RM1,800 to RM2,500 per month. In PW3's view to become a company secretary, one has to embark upon a three-year special course and the entry requirements were 'A' Levels. This evidence of PW3 was not challenged by the defendants.

From the evidence it is clear to me that the plaintiff had not passed her 'A' Level examinations and that she had not entered for any secretarial course. For the purpose of this case the loss of earnings should be on the basis of a clerk-cum-typist only.

At the time of the accident the plaintiff was 24 years of age and at the time of the trial she was 37 years of age. The operation that caused the paralysis took place on 19 July 1982. As the incident occurred before the amendment, the pre-amendment provisions of the law applies in her case. Therefore, there is no question of taking 55 years as the cut off point. Anyway, being a lady, in my opinion her working life would be until the age of 50 years.

Taking that her working life span would be until the age of 50 years and at the time she was 24 years of age, she had about 26 years of working life left. I would, following the decision in *Yeap Cheng Hock v. Kajima-Taisei Joint Venture* [1973] 1 MLJ 230 and as followed by Abdul Malek J. in *Wong Fook's (supra)* case take off one third for contingencies. This leaves 20 years' purchase. Since this is a pre-amendment case, I have to assess the claim on pre and post-trial basis.

***(a) Pre-Trial Loss***

From 1982 to date of judgment the period is 15 years. This was the pre-trial loss.

It is normal for any employee in his expectations of salary increment, but I have to be realistic in the whole situation. There is no dispute that at the time of the incident the plaintiff was working in the private sector where the increment was based on work performances, profit and other factors. In my opinion the average income of the plaintiff should be in the region of RM650 per month. Using the direct multiplier method the pre-trial loss is RM650 x 15 x 12 = RM117,000.

This will bear interest at 4% per annum from 19 July 1982 to the date of full payment.

*(b)* ***Post-Trial Period***

The post-trial years of purchase will be 20 minus 15 which is five years.

For this post-trial period, though PW3 gave evidence that a clerk-cum-typist is to be paid the sum of RM1,100 to RM1,300 a month, I am of the opinion that the realistic figure here is in the region of RM800 a month. On actuarial basis the total post-trial loss is RM41,562.97. This of course will bear no interest.

*(c) **EPF Contributions***

The employer's letter (P6) and EPF contributions (P7A-P7F) were agreed documents and tendered by consent. I have determined the remaining working life of the plaintiff is 20 years and determined that the pre-trial loss for 15 years at RM650 and the post-trial loss for five years at RM800 a month, the loss in EPF contributions by the employer are as follows:

(a) For the pre-trial at RM650 the employer's contribution should be RM73 per month. Therefore, for 15 years the contribution would be RM73 x 15 x 12 = RM13,140. The plaintiff is entitled to 4% interest from 19 July 1982 to date of judgment.

(b) For the post-trial period at RM800 per month the employer's contribution is RM96 per month. Therefore, for five years the employer's contribution would be RM96 x 5 x 12 = RM5,760. No interest is allowed on this amount.

When I delivered my decision on 8 April 1999, I had given different figures for the EPF contributions. After delivering the decision I discovered that the calculations were based on working life until 55 years of age and on the EPF tables supplied by the plaintiff's counsel. It appears to me that the employer's contributions have changed from time to time. Based on the changes during the material times the correct calculations are as above.

(ii) ***Transport Charges***

I accept as reasonable the plaintiff's claim of RM100 as transport charges per month. I will award for the pre-trial period for 13 years only. For the first two years, it is reasonable to assume that she would not be travelling.

For 13 years, this amounts to RM100 x 13 x 12 = RM15,600. This will fetch interest at 4% per annum from 19 July 1985 to date of judgment.

For the post-trial period of five years, the transport charges at RM100 x 5 x 12 amounts to RM6,000. There will be no interest on this.

(iii) ***Cost of Diapers***

For the pre-trial period of 15 years, I will award the sum of RM60 per month which works out to RM60 x 15 x 12 = RM10,800. This will fetch interest at 4% per annum from 19 July 1982 to date of judgment.

For the five years post-trial period, the cost of diapers amounts to RM60 x 5 x 12 = RM3,600. This of course will not attract interest.

(iv) ***Nursing Care***

The plaintiff claimed the sum of RM500 per month for nursing care and she was not cross-examined on this. Notwithstanding that there was no cross-examination, I am of the view that the claim was on the high side taking into consideration she had been awarded loss of earnings and taking into consideration the cost of employing maids. For this purpose I made the award based on three different periods:

(a) For the first ten years of the pre-trial, I am of the view that the sum of RM350 is reasonable. As such for ten years she is entitled to RM350 x 10 x 12 = RM42,000.

(b) For the next five years of the pre-trial, I am of the view that the sum of RM500 is reasonable. As such she is entitled to RM500 x 5 x 12 = RM30,000.

(c) For the post-trial period of five years, I am of the opinion that the sum of RM500 is reasonable. As such she is entitled to RM500 x 5 x 12 = RM30,000.

Interest at 4% per annum will be awarded on (a) and (b) from 19 July 1982 to date of judgment. No interest is to be given on (c).

The total award is as follows:

| | |
|---|---|
| GENERAL DAMAGES | RM 180,000 |
| SPECIAL DAMAGES: | |
| (i) Loss of earnings: | |
| (a) Pre-trial loss | RM 117,000 |
| (b) Post-trial loss | RM41,562.97 |
| (ii) EPF Contributions by Employer: | |
| (a) Pre-trial loss | RM 13,140 |
| (b) Post-trial loss | RM 5,760 |
| (iii) Transport Charges: | |
| (a) Pre-trial loss | RM 15,600 |
| (b) Post-trial loss | RM 6,000 |

(iv) Cost of Diapers:

| | | |
|---|---|---|
| (a) Pre-trial loss | RM | 10,800 |
| (b) Post-trial loss | RM | 3,600 |

(v) Cost of Nursing Care:

| | | |
|---|---|---|
| (a) Pre-trial loss | RM | 72,000 |
| (b) Post-trial loss | RM | 30,000 |

The interest on those special damages as I have stated earlier. As to general damages the interest shall be at 8% per annum from the date of service of the writ to date of judgment.

***Costs***

Following the decision in *Kamalan's case (supra)* and as I myself have seen the amount of work put into this case, I am of the view that it is reasonable that pursuant to O. 59 r. 19(1) of the Rules of the High Court 1980, to certify that the costs to be awarded are fees for two counsels in favour of the plaintiff, such costs to be taxed and to be paid by the defendants.